Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

JOSEPH ZADEH, DO
PO BOX 741865
DALLAS, TX 75374

Respondent Name

NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4618-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DD EXAMS" and "REQUIRED TESTING REQUESTED BY DD"

Amount in Dispute: $525.64

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Dispute notice was sent on August 10, 2010. No response to MFDR

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2011	99456-WP-W5 and 95851	$525.64	$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. Texas Labor Code Title 5, Subtitle A, Chapter Subchapter A, in §408.0041 provides general provisions for DD Examinations and carrier responsibilities for payment of such services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 08, 2011
   - ANSI214 – 214 - WORKERS COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT.
   - SRS406 – CLAIM DENIED. PLEASE CONTACT THE SRS CLAIMS EXAMINER FOR FURTHER INFORMATION.

   Explanation of benefits dated June 28, 2011
   - 148 – THIS PROCEDURE ON THIS DATE WAS PREVIOUSLY REVIEWED
   - ANSI18 – 18 - DUPLICATE CLAIM/SERVICE.
   - ANSI214 – 214 - WORKERS COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT.
   - SRS406 – CLAIM DENIED. PLEASE CONTACT THE SRS CLAIMS EXAMINER FOR FURTHER INFORMATION.

Issues

1. The carrier has addressed issues of compensability for the claim. How does this affect a Division ordered Designated Doctor (DD) examination order?
2. Has the DD examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is CPT code 95851 included in the MMI/IR examination?
4. Is the requestor entitled to additional reimbursement?

Findings

1. On the EOBs dated June 08, 2011 and June 28, 2011, the respondent denied reimbursement based upon "ANSI214 – 214 - WORKERS COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT." and "SRS406 – CLAIM DENIED. PLEASE CONTACT THE SRS CLAIMS EXAMINER FOR FURTHER INFORMATION."

   Texas Labor Code §408.0041 states in part (a)(1)(2)

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   (1) the impairment caused by the compensable injury;
   (2) the attainment of maximum medical improvement;

   Texas Labor Code §408.0041 states in (h)(1):

   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f).

   The completion of a Designated Doctor order by the Division is payable per the above statute and is not subject to the status of the claim.

2. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was determined. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Lumbar Range of Motion (ROM) tests were performed. However, the narrative states that the IR was "best rated under DRE (Diagnosis Related Estimate) Category II for 5% whole person impairment rating of the lumbar spine for muscle guarding." Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for IR using DRE method is $150.00. Therefore, the MAR for the MMI/IR examination is $500.00. This amount is recommended.

3. The provider also billed the amount of $45.00 for CPT code 95851 for ROM testing for the MMI/IR examination. There was no reimbursement for this CPT code by the respondent. However, two medical fee guideline rules address testing that is included in the overall MMI/IR examination reimbursement.

   28 Texas Administrative Code 134.204 states in part (j)(1)(E):

   (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
   (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:
   (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

   Also, 28 Texas Administrative Code 134.204 states in part (j)(4)(C)(ii):

   (ii) The MAR for musculoskeletal body areas shall be as follows.
   (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
   (II) If full physical evaluation, with range of motion, is performed:
   (-a-) $300 for the first musculoskeletal body area; and
   (-b-) $150 for each additional musculoskeletal body area

   Per the rules above, ROM is included in the reimbursement for the MMI/IR exam and is not separately payable. No additional amount for CPT code 95851 can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $500.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 28, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.